VERMONT
AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury, VT 05671-2306
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Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
Fax (802) 871-3318

September 3, 2014

Ms. Susanne Shapiro, Administrator
West River Valley Assisted Living Residence
Po Box 341
Townshend, VT 05353-0341

Dear Ms. Shapiro:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **August 12, 2014.** Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

PC:jl

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	1007	A. BUILDING: _____ B. WING _____	C 08/12/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST RIVER VALLEY ASSISTED LIVING RESII	PO BOX 341 TOWNSHEND, VT 05353

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R100	Initial Comments: An unannounced onsite re-licensing survey and complaint investigation was conducted by the Division of Licensing and Protection on 8/11/14 and 8/12/14. The findings include the following:	R100		
R172 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.h All medicines and chemicals used in the home must be labeled in accordance with currently accepted professional standards of practice. Medication shall be used only for the resident identified on the pharmacy label. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to ensure that all all medications in the home are labeled in accordance with current accepted professional standards of practice. Medication shall be used only for the resident identified on the pharmacy label. The findings include the following: Per observation during review of medication storage on 8/12/14 at 8 AM, a syringe with 1 millimeter (cc) of pink liquid was observed in the refrigerator designated for medication storage. The syringe was placed on a piece of paper with a hand written first name. Per interview with a Medication Care Assistant on 8/12/14 at 8 AM, confirmation was made that s/he witnessed the medication (Vitamin B12), being prepared by a Registered Nurse (RN) on 8/10/14. At the time the RN was to administer the medication, s/he discovered that the resident	R172	R172 Resident Care & Home Services RN leaving a prefilled syringe with insufficient label was identified and this matter was addressed. The RN was well aware that she had failed to complete this task from which she had been interrupted, and she is equally aware that this was incorrect practice. Process of withdrawing medication/administering injections was reviewed with this RN and will be part of any RN orientation in the future. See R176 Paragraph #2	8/11/14

R172, R176, R179, R217, R224, R247, R253, R266, R311 + R314 POCs accepted 9/2/14 mBertrand RN/PMC

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R172	Continued From page 1 went out of the facility. The RN then returned the filled syringe back to the medication refrigerator where it was observed during tour. *Reference: Based on Standards of Professional Nursing Practice, Lippincott Manual of Nursing Practice 19th edition, Wolters Kluwer Health/Lippincott Williams.	R172	R176 Resident Care and Home Services The facility procedure is that we discard resident medications after death or discharge promptly or within one business day. The finding during survey was out of the ordinary in that second RN/Director of facility had been on medical leave and the hospice RN away on vacation, so the medications were left in facility storage room too long. We will make it a practice to call on our third RN (who mostly provides on-call service for the facility) to be the witness to a discard medications when the regular RNs are unavailable. As a follow up after facility survey, all outdated medications have now been discarded. Narcotics have been discarded with witness to discard signatures, a routine practice already. Refrigerator was cleaned/ defrosted by RN and a temperature log was reinstated and will be kept by third shift staff ongoing. Facility RNs will have a weekly log in medication room to ensure proper hygiene and storage of medications as well as disposal of those medications that need to be disposed. Policy updated to include that discontinued medications will be discarded within one business day when a resident dies or is discharged. Facility Nurse Manager (RN) and Executive Director (RN) will be the responsible party for maintaining these procedures, and both will call on the third RN employed by facility when other RNs are unavailable.	8/13/14
R176 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.h (4) Medications left after the death or discharge of a resident, or outdated medications, shall be promptly disposed of in accordance with the home's policy and applicable standards of practice. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to properly dispose of narcotics/controlled substances after the death of 2 residents, disposal of outdated medications and disposal of multiple bubble packs that contain prescription and over the counter medications that have been discontinued for use. The findings include the following: 1. Per observation on 8/11/14 at approximately 1 PM of the medication storage room, Amoxicillin 500 milligram (mg.) tablets for Resident #10, prescribed by the physician, directs to administer 4 tablets before a dental appointment. The medication has an expiration date of 12/7/13.	R176		

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R176	Continued From page 2	R176		

Per interview with the Registered Nurse (RN) Manager during the observation, confirmation is made that the medication is outdated and needs to be replaced.

Per facility Medication Management Policy and Procedures, outdated medications left after the death or discharge of a resident or refused medications will be destroyed by the Licensed Practical Nurse (LPN) or the Registered Nurse (RN).

2. Per observation on 8/11/14 at approximately 1 PM of the medication storage room, Lorazepam 0.5 milligram (mg.) tablets are stored for Resident #11, who died on July 3, 2014.

Per interview with the Registered Nurse (RN) Manager during the observation, confirmation is made that the medication should have been destroyed at the time of the resident's death.

Per facility Medication Management Policy and Procedures, outdated medications left after the death or discharge of a resident or refused medications will be destroyed by the Licensed Practical Nurse (LPN) or the Registered Nurse (RN). Narcotics/controlled medications will be destroyed with both RN and LPN present.

3. Per observation on 8/11/14 at approximately 1 PM of the medication storage room, for Resident #12, who died on July 17, 2014, the following medications are being stored:
Morphine Sulfate 9 tablets;
Oxycodone 10 milligrams (mg.) 19 tablets;
Morphine Sulfate 30 mg. 10 tablets Bubble Pack #1;
Morphine Sulfate 30 mg 10 tablets Bubble Pack

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R176	Continued From page 3	R176		

#2;
Morphine Sulfate Liquid 2 bottles each containing 30 millimeters (ml.) labeled
100 mg. per 5 (ml.).

Per interview with the Registered Nurse (RN) Manager during the observation, confirmation is made that the medication should have been destroyed at the time of the resident's death.

4. Per observation on 8/11/14 at approximately 1 PM of the medication refrigerator, Influenza Vaccine (Lot #R52506) in pre filled syringes were found frozen in place, still in their original packing. 2-6 of the prefilled syringes were unable to be dislodged from the back of the refrigerator due to frost and 4 prefilled syringes that were removed were identified as having an outdate of June 27, 2014.

Per interview with the Resident Attendant at the time of the observation, s/he confirms that the vaccine is outdated, frozen to the refrigerator and that the refrigerator needs to be defrosted and cleaned. S/he also confirms that temperature logs are not maintained on the medication refrigerator and that the temperature on the thermometer currently registers at 60 degrees which must be inaccurate.

4. Per observation of medication storage on both 8/11 and 8/12/14, multiple bubble packs containing prescription medications and over the counter medications, that have been discontinued, are located in a unlocked drawer in the medication room.

Per interview with Registered Nurse (RN) Manager on 8/11/14 at approximately 1 PM, s/he confirms that the discontinued medications need

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R176	Continued From page 4 to be discarded.	R176		
R179 SS=A	V. RESIDENT CARE AND HOME SERVICES 5.11 Staff Services 5.11.b The home must ensure that staff demonstrate competency in the skills and techniques they are expected to perform before providing any direct care to residents. There shall be at least twelve (12) hours of training each year for each staff person providing direct care to residents. The training must include, but is not limited to, the following: (1) Resident rights; (2) Fire safety and emergency evacuation; (3) Resident emergency response procedures, such as the Heimlich maneuver, accidents, police or ambulance contact and first aid; (4) Policies and procedures regarding mandatory reports of abuse, neglect and exploitation; (5) Respectful and effective interaction with residents; (6) Infection control measures, including but not limited to, handwashing, handling of linens, maintaining clean environments, blood borne pathogens and universal precautions; and (7) General supervision and care of residents. This REQUIREMENT is not met as evidenced by: Based on staff interview and in-service record review, the facility failed to ensure that 1 of 5 sampled direct care employees, has received at least twelve (12) hours of training each year. The findings include the following:	R179	R179 Resident Care and Home Services The caregiver identified with only 9.5 hours of education in the last 12 months has been scheduled to come in for the time it takes to catch her up on the required training - at least a 3 hour period of training. It has been the practice in the facility that caregivers are notified, in writing, in January each year, of the status of their training requirements. We will continue to do this, and then we will repeat this notification in June/July to avoid any lapse of training requirements. It is our plan to complete self study modules for all mandatory topics of education for when our staff in order to be better equipped to be in full compliance with regulations for facility education, also when our staff is unable to attend training in person. Self study modules for mandatory in-service topics will be developed by 9/30/14. On 8/19/14 a staff meeting for all employees was held. During this meeting we reviewed with all staff what they need to do to catch up with in—services. They all received written notification of their education/in-service status.	9/30/14

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R179	Continued From page 5 Per review of in-service records for 1 of 5 Resident Care Assistants, s/he did not completed the twelve hours of education as required. The Resident Care Assistant has completed 9.5 hours of education offered, but has not had in-service training in the areas of Respectful Communication, Infection Control, General Care and Supervision in the past twelve month period. Per interview with Registered Nurse Manager on 8/11/14 at approximately 5 PM, confirmation is made that the direct care assistant has not completed the 12 hours of required education in the past twelve months.	R179		
R217 SS=A	VI. RESIDENTS' RIGHTS 6.5 Each resident shall be allowed to associate, communicate and meet privately with persons of the resident's own choice. Homes shall allow visiting hours from at least 8 a.m. to 8 p.m., or longer. Visiting hours shall be posted in a public place. This REQUIREMENT is not met as evidenced by: Based on observation and resident interview, the facility failed to allow 1 of 3 residents in the sample, Resident #5, to communicate privately with persons of his/her own choice. Findings include: During interview with Resident #5 on 8/11/14, h/she proceeded to tell the surveyor about a Google Voice text account that was set up for him by a staff member. H/she stated that on	R217	R217 Residents' Rights The staff member who was involved with the given example of violation of Residents' Rights for resident #5 was counseled immediately after survey. A write up of this conversation was placed in her personnel file following counseling with the Director and Nurse Manager. On 8/19/14 Residents' Rights were reviewed with all staff members, a copy of Residents' Rights was given to ALL employees with a request to sign off that they were read and understood the document. These signed Residents' Rights were then filed in each employee personnel file. The facility reviews Residents' Rights routinely for all new hires. We review annually and following the survey we have decided to add a specific review of Residents' Rights each year when delegated staff go through their review of the delegation process. We have also updated our personnel policy to advise staff not to exchange their personal phone numbers and email addresses with residents.	8/19/14

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R217	Continued From page 6 numerous occasions the calls went to the phone of the staff and the staff member would answer the calls or call the numbers back and ask questions as to who they were and why they wanted to speak with Resident #5. H/she then showed me the social media text conversations from the care giver to people that were looking for the resident. H/she also showed me a text conversation from one of his/her contacts dated 7/18/14, wanting to know who it was that was answering messages meant for Resident #5. The communications were private and Resident #5 stated that it "stressed" him/her out that this was occurring. Review of the communications provide information as to the caregiver's name and personal cell phone number and with interception of calls on at least 5 occasions between 5/21/14 and 7/18/14.	R217		
R224 SS=D	VI. RESIDENTS' RIGHTS 6.12 Residents shall be free from mental, verbal or physical abuse, neglect, and exploitation. Residents shall also be free from restraints as described in Section 5.14. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview and record review, the facility failed to keep 1 of 3 residents in the sample, Resident #5, free from verbal and mental abuse. Findings include: On 8/11/14 during interview with Resident #5, h/she made a statement that indicated a care giver had made a remark in the dining room that indicated h/she was a liar. Per interview with the	R224	R224 Residents' Rights In addition to the above (R217) another staff member/caregiver was counseled by the Nurse Manager and Executive Director about Resident's Rights related to being free from mental, verbal, or physical abuse, neglect, or exploitation. She too had a write up from counseling placed in her personnel file, and was party to staff meeting review of Resident's Rights as described above under R217.	8/19/14

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R224	Continued From page 7 Registered Nurse Manager, the allegation was investigated. Per review of the investigation, there was a written statement of a witness to the incident on 8/7/14 that a care giver told Resident #5 that he had a "Pinocchio's nose" and wasn't being truthful. The comment was made in regards to a statement that Resident #5 had made regarding an incident that occurred involving another resident that no longer resides at the facility. This comment was made in a public area with other staff and residents present.	R224		
R247 SS=E	VII. NUTRITION AND FOOD SERVICES 7.2 Food Safety and Sanitation 7.2.b All perishable food and drink shall be labeled, dated and held at proper temperatures: (1) At or below 40 degrees Fahrenheit. (2) At or above 140 degrees Fahrenheit when served or heated prior to service. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to assure that all perishable food is labeled and dated. The findings include the following: Per observation on 8/11/14 at 11:20 AM, during the tour of the Dietary Department with the Food Service Supervisor (FSS), a refrigerator storing multiple food products for distribution, contained 21 individual servings of cake, raspberries and fruit, labeled with contents, but not dated as to when the deserts was placed in the refrigerator. Whipped Cream dated 8/5/14 was also stored in the refrigerator.	R247	R247 Nutrition and Food Services After the survey the requirement that all perishable food and drink shall be labeled, dated and held at proper temperatures was reviewed with the Kitchen Manager – who reviews all such regulations with her staff on a regular basis, upon hire/orientation and annually. The 21 desserts without dates were produced the day before and labeled for our 21 meals-on-wheels clients. The desserts were made on Sunday to be delivered on Monday - the day of the survey. It was an unusual error that no date was on. It is the responsibility of Kitchen Manager to review cooling areas daily for any outdated food and leftovers. The facility will institute that this is done at the same time that temperature logging is done for all coolers and freezers.	8/11/14

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R247	Continued From page 8 Per interview with the FSS at the time of the tour, confirmation is made that the desserts do not identify the date they were placed in the refrigerator as noted by other stored items and the whipped cream should have been discarded after five (5) days as per facility policy.	R247		
R253 SS=F	VII. NUTRITION AND FOOD SERVICES 7.3 Food Storage and Equipment 7.3.c All food service equipment shall be kept clean and maintained according to manufacturer's guidelines This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to assure that all food service equipment is kept clean and maintained according to manufacturer's guidelines. The findings include the following: Per observation during the tour of the Dietary Department with the Food Service Supervisor (FSS) on 8/11/14 at 11:20 AM, s/he made notice of a new ice machine. Surveyor questioned the FSS when the unit was last sanitized and s/he responded that the unit is maintained by maintenance. Per interview with the Property Manager, (who oversees maintenance), on 8/12/14 at approximately 11:37 AM, s/he confirms that the ice machine was shipped to the facility on 8/5/13, the unit was installed and put into use in October 2013 and has not been sanitized since it was put into use.	R253	R253 Nutrition and Food Service Following discovery of this, our ice machine was cleaned on 8/12/14. It is our policy and practice that all food service equipment shall be kept clean and maintained according to guidelines. At this facility, the Maintenance Department is responsible for sanitizing of the ice machine. Property Manager is aware now that the manual for the new facility ice machine states the recommended cleaning rotation should be semi-annual. Property Manager will assure that maintenance staff is aware and follows this routine in the future. As with all our other re-occurring inspections/servicing, we have added this task to our maintenance checklist/calendars. We have also attached a dated service cleaning tag to the machine which shows when the work was done and when it is to be done next.	8/12/14

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R253	Continued From page 9 Per manufacturer's instillation, use and care manual the ice machine should be cleaned and sanitized every six months. (Page 15)	R253		
R266 SS=E	IX. PHYSICAL PLANT 9.1 Environment 9.1.a The home must provide and maintain a safe, functional, sanitary, homelike and comfortable environment. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to provide and maintain a safe environment. The findings include the following: 1. Per tour of the facility on 8/11/14 at approximately 11 AM, for Resident #7, nine (9) small oxygen cylinders are stored in the upright position in the resident's closet, not secured. Per interview with the Registered Nurse (RN) Manager on tour, confirmation is made that the oxygen cylinders are not secure and do not follow educational guidelines (Page #21) provided to Resident Assistants. ["Never store any cylinder in closet or unventilated space. Secure cylinder at all times in a base or cart."] 2. Per tour of the facility on 8/11/14 at approximately 11 AM, for Resident #8, eight (8) small oxygen cylinders and one (1) large cylinder are stored in the upright position in the resident's closet, not secured. Per interview with the Registered Nurse (RN) Manager on tour, confirmation is made that the oxygen is not	R266	R266 Physical Plant Oxygen cylinders small and large have now been placed in open areas and secured in appropriate storage containers. The facility will switch vendors for any future oxygen needs, related to difficulties with current vendor in terms of timely deliveries as well as careful storage upon delivery of oxygen supplies. RNs will institute monthly rounds to check oxygen supplies and storage. Training and re-training on oxygen will be added annual delegated training.	8/13/14

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R266	Continued From page 10 secure and does not follow educational guidelines (Page #21) provided to Resident Assistants.	R266		
R311 SS=E	X. PETS 10.2.e Pet health records shall be maintained by the home and made available to the public. This REQUIREMENT is not met as evidenced by: Based on interview the facility failed to maintain health records and/or make them available to the public, for 2 or the 5 cats that live in the home with their owners. The findings include the following: Per facsimile received from the Executive Director (ED) on 8/13/14, s/he was unable to produce health records for two (2) cats that are owned by Resident #7 and Resident #13.	R311	R311 Pets Families have been contacted in order to come into compliance with maintaining of cat records for the two cats found to have no records/outdated records. The missing records/outdated vaccinations will be remedied by 9/5/14. Property Manager and Executive Director will obtain cat vaccination records as part of any admission of incoming residents who move in with a cat. Additionally, cat records will be reviewed annually at the time when resident assessments are due.	9/5/14
R314 SS=E	XI. RESIDENT FUNDS AND PROPERTY 11.2 If the home manages the resident's finances, the home must keep a record of all transactions, provide the resident with a quarterly statement, and keep all resident funds separate from the home or licensee's funds This REQUIREMENT is not met as evidenced by: Based on interview and medical record review the facility failed to provide 3 of 9 sampled residents with a quarterly statement that records all transactions of the resident's personal petty cash account. The findings include the following:	R314		

Division of Licensing and Protection

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST RIVER VALLEY ASSISTED LIVING RESII	PO BOX 341 TOWNSHEND, VT 05353

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R314	Continued From page 11 1. Per review of petty cash ledger on 8/12/14 at approximately 3 PM, for Resident #2, evidences that the account was open on 11/15/11. Per interview with the Executive Director on 8/12/14 at approximately 3 PM, s/he confirms that no statements of transactions have been sent to the resident and/or family since 11/15/11. 2. Per review of petty cash ledger on 8/12/14 at approximately 3 PM, for Resident #4, evidences that the account was open on 2/1/14. Per interview with the Executive Director on 8/12/14 at approximately 3 PM, s/he confirms that no statements of transactions have been sent to the resident and/or the resident's legal representative since 2/1/14. 3. Per review of petty cash ledger on 8/12/14 at approximately 3 PM, for Resident #9, evidences that the account was open on 2/1/14. Per interview with the Executive Director on 8/12/14 at approximately 3 PM, s/he confirms that no statements of transactions have been sent to the resident and/or the resident's legal representative since 2/1/14.	R314	R314 Resident Funds and Property Resident #2 had not been given a quarterly statement at the time of the survey. There had been no transactions on this resident's account for 2 years. To correct this, the family member/DPOA was sent an account statement on 8/13/14. Quarterly statements will be sent in the future even if there are no transactions, as per regulations. All residents with a petty cash fund at the facility were sent quarterly statements on 8/13/14, and they will receive the next statement of account by 11/13/14 and quarterly thereafter.	8/13/14